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Report to the State of Montana: Legislative Mental Health Study

EXECUTIVE SUMMARY

Purpose and Scope of the Report

In commissioning this study of the Montana mental health system, the Montana Legislature has taken another major step forward in the State's process of mental health systems transformation. Montana faces significant access challenges that include its primarily rural and frontier character, a limited mental health workforce, a large population in poverty and numbers of under- and un-insured. The state's system transformation requires intensive coordination of services, funding and information; creative approaches to expanding eligibility; and the development of new and expanded services for children and adults that also meet the needs of special populations such as Native American Tribes, veterans and those in the corrections system. The change process also requires the input and support of local advisory groups – those best qualified to describe the needs of their communities.

This report addresses community needs, additional services needed, the extent to which Montana is fully using existing state and federal resources, and additional opportunities or resources that may exist. Financial and organizational options for the state and their costs are described, with analysis of recommendations for system improvement. The report centers on the concerns and feedback of the Montana State Legislature and a broad range of consumer and provider stakeholders, and is designed to contribute to an achievable and measurable state mental health systems transformation plan.

Key Findings

Montana is a progressive state that has been creative and proactive in piecing together multiple state, federal and local sources of funding to serve as many of its citizens as possible, wherever they live. Montana has been able to build its children's mental health system on Medicaid and SCHIP, creating a comprehensive mental health system with relatively generous eligibility standards. As with many other states, however, Montana has had to patch together funding streams and services that do not consistently provide equal access or types of service across populations and payer systems. While state officials have developed a waiver and other plans to make improvements, this study is an opportunity to make more comprehensive improvements. Key findings of this study are nested in five broad categories:

1) Coordination of services, payments, funding streams and data;
2) Eligibility, access and underlying funding mechanisms;
3) Improvements in the community based system of care;
4) Services for special populations; and
5) Support for local planning.

Coordination. Over time Montana has seized multiple opportunities to implement new initiatives with different configurations of service, funding streams and reporting requirements, under the auspices of different state agencies. This challenges management oversight and interagency communication, and often leaves consumers in a quandary about how to navigate the system. The system needs an

overarching structure to coordinate service programs, make and track reimbursements by funding stream, and provide regular data reports that are consistent across state agencies.

Eligibility, access and underlying funding mechanisms. Inequities in service access and reimbursement exist between the child and adult systems; levels of severity of mental illness; income levels; Medicaid vs. state payer systems; and across urban, rural and frontier areas. Limitations in Medicaid eligibility, especially for adults, compromise access, can result in the exacerbation of symptoms and hence need for more intensive and costly services, and shift costs from potential federal matches to state funds. There is potential for making better use of federal funds through Medicaid Waivers and expanded eligibility.

Community based system of care. Although both adult and child mental health service systems are relatively comprehensive in the State's Medicaid plan compared to other states, some services need expansion, with attention to specific regions of the state, rural areas in particular. Over-utilization of Montana State Hospital, despite constructive steps to control admissions, is clearly stressing hospital capacity and resulting in unnecessarily high costs to the State. Utilization data suggest that many adults with Serious and Disabling Mental Illness (SDMI) are not receiving the services they need. Crisis services as well as psychiatry are key target areas for both adults and children. Residential placements for children, while reduced through recent initiatives, can be further controlled through expansion and enhancement of intensive community based family services and supports.

Services for special populations. *Native Americans* – The Indian Health Service (IHS) and two independent tribal facilities provide basic mental health and social services on all reservations. They face challenges in maintaining mental health staff and too often see people when their problems have reached a crisis. This system needs more resources, potentially through expansion of its third party revenues. *Adult and Juvenile Corrections* – There are well documented increases in the criminal justice system of mental illness, substance abuse and co-occurring disorders, yet mental health expenditures represent a very small portion of the Corrections budget. The standard of mental health care in Corrections needs improvement; expansion of case management for those who are diverted or released is critical; and there is potential for maximizing Medicaid and other third party payments to improve mental health care in community corrections. *Veterans* - Montana's National Guard has made improvements in identification and referral of guardsmen with mental health needs, and the VA has expanded its mental health treatment and trauma training for eligible veterans. Capacity for outreach is limited, however, and children of discharging veterans are often not immediately eligible for Medicaid and may lack other forms of health insurance.

Support of local planning. The development of responsive community based systems of care depends on the input and effectiveness of local advisory groups. While Montana has been quite progressive in its development of Local Advisory Councils (LAC), Service Area Authorities (SAA) and Kids Management Authorities (KMA), the advisory process suffers from confusion regarding the definition of their respective roles, memberships and relationships with state entities, inconsistent dissemination of needed systems information, and limited resources for statewide development.

Key Recommendations

The following major recommendations are highlights of detailed recommendations that follow and are organized in tandem with the five key findings, as follows:

Coordination. The state should take action to improve coordination in administering the mental health system through co-location, improved coordination and consistent leadership of the Addictive and Mental Disorders Division (AMDD) and the Children's Mental Health Bureau (CMHB), with more effective financing rules and other changes. In addition the Department of Public Health and Human Services (DPHHS) should consider a more ambitious restructuring of the mental health system. It should develop a plan for a quasi-public Care Coordination Organization (CCO) to manage mental health services for children and adults under a 1915(b) or 1115 waiver. This CCO, in essence a Managed Care Organization, would coordinate services currently overseen by different state agencies, and make reimbursements for state funded services as well as Medicaid fee for service. The CCO would track expenditures by funding stream and disseminate standard reports across state agencies. An 1115 Research and Demonstration waiver would allow the state to consolidate its Health Insurance Flexibility and Accountability (HIFA) waiver terms into the managed care approach. The state should consider whether to include substance abuse services also.

Eligibility, access and underlying funding mechanisms. Montana's proposed Health Insurance Flexibility and Accountability (HIFA) waiver is targeted to expand Medicaid eligibility to SDMI adults and certain other specific groups. It would allow most current Mental Health Services Plan (MHSP) enrollees access to the comprehensive services provided through Medicaid, and would garner federal match for these services. In addition to active follow-up of the HIFA waiver, Montana should consider the following Medicaid eligibility expansion efforts:

1) Appropriate funds for and adapt 72 Hour Presumptive Eligibility (crisis response and stabilization services) as needed to create a strong and accessible crisis service that can effectively divert many clients from hospitalization;
2) Ensure maximum possible enrollment of adults into Medicaid by rolling Medicaid application into the MHSP re-application process, assisting those who are incarcerated in making Medicaid applications and keeping them on suspended enrollment so that that they will qualify for services immediately upon release; and
3) If the HIFA Waiver is not approved, consider raising income eligibility levels for adults and revising SDMI levels for Medicaid and/or MHSP as funds may allow.

Community based system of care. For adults, further and more consistent control of state hospital utilization is needed. Key community services to support hospital diversion and step-down include more accessible crisis services, expanded psychiatry services supported by more attractive rates and telepsychiatry, and the deployment of trained Peer Recovery Support Specialists in the community. The DPHHS Extraordinary Case Review initiative should be expanded and a more extensive chronic disease management approach considered. Further efforts to expand community based acute inpatient capacity as alternatives to reliance on Montana State Hospital should be considered (in the context of an overall reduction in Montana State Hospital beds). This would be aided by efforts to increase housing options for the chronically mentally ill as well as by expansion of Montana's telemedicine initiatives.

For children, access to child psychiatry must be improved through aggressive recruitment and the consideration of higher rates for psychiatry services. Wraparound service planning with intensive care coordination should provide more coordinated access to a broadened range of intensive community based services and supports that should include paraprofessional family support, respite, and flexible funds to purchase needed goods and services that fall outside of definitions of Medicaid Medical Necessity. The child system will benefit from improved utilization and outcome reporting that holds providers responsible for maintaining children in the community rather than in out-of-home placements. Both the adult and child systems will benefit from improved integration of behavioral and primary care.

Services for special populations. *Native Americans* will benefit from a long-term strategy to enhance DPHHS collaborations with IHS and independent tribes to better understand their needs, enhance cultural competency, and make best use of combined mental health resources. A joint approach to developing accurate DPHHS and IHS data on services will support a collaborative planning process for improving access for Indians. Continued cooperation to maximize Medicaid enrollment and Medicaid billing can further extend IHS resources. *Corrections* will benefit from the development of data sharing systems by DPHHS/DOC to support the monitoring and oversight of youth in or at risk of residential treatment as well as methods to minimize any gap in Medicaid enrollment upon release for those who are Medicaid eligible. DPHHS and DOC should periodically review DOC's mental health expenditures to evaluate braided funding mechanisms for the treatment of incarcerated adults. For *Veterans* CMHB should closely coordinate with the Division of Military Affairs to provide information on CHIP eligibility that can be communicated to veterans and their families during the process of transition. The National Guard's plans for continuing post-discharge assessments in the 2 years following discharge should be supported by state funds if federal funds are not appropriated. Screening, outreach and community based service access should be supported by enhanced collaboration between AMDD, the National Guard and the VA.

Coordinated support of local planning. Consumers will benefit from broader consensus on the vision, mission and goals of LAC, SAA and KMA community oversight. Better definition is needed regarding responsibilities and relationships between these groups and state authorities such as DPHHS, AMDD, CMHB and the Mental Health Oversight Advisory Council. Membership should be reviewed for greater inclusiveness, beginning with law enforcement. Similar planning areas should be agreed upon between adult and child systems. Standard reports on prevalence, service access, utilization and outcomes data should be shared with advisory groups, providing county-level data with regional and state comparisons. To become truly effective across the state, the collaborative advisory process is likely to require a greater investment of resources.

Conclusion

In this six-month study by the DMA Health Strategies team, Montana has demonstrated that the state, in response to significant geographic, economic and cultural challenges, has seized many key opportunities to make system improvements, a recent one being application for a HIFA 1115 Medicaid waiver. Study findings have led to five key recommendation areas, the most ambitious of which is the first – the development of a Care Coordination Organization to address fragmentation in the state's systems of service delivery, financial reimbursement and tracking, and data reporting. This major systems change will support efforts to expand Medicaid eligibility and develop and coordinate a more comprehensive array of community based services for adults, children and special populations such as Indians, veterans, and youth and adults in Montana's corrections system, thus ultimately reducing utilization of high cost residential, hospital and corrections facility services. Critical to the success and sustainability of these efforts is the greater refinement of and support for local advisory groups and processes, through improved membership, role definition, data sharing and resources for statewide development. With its strong foundation and track record, the state of Montana shows great potential for being a leader amongst frontier states in mental health system of care transformation.

Care Coordination

- Strengthen linkages between police, jails, prisons and crisis centers.
  - Develop a pilot for mental health screening for individuals entering jails or prison and develop processes for collecting and sharing results across the treatment and judicial system. Use the data as the basis for a needs assessment of individuals who need services while in custody and ensure that pre-release planning incorporates referral to and monitors access to services where needed. A small seed grant may be all that is needed to spark this effort with prison officials and pre-release staff.
- Consider opportunities to coordinate and unify management of CHIP and Medicaid mental health.
- Expand the scope and improve the efficiency and effectiveness of KMAs or related entities:
  - Make the current KMA process more efficient by increasing support staffing and other resources.
  - Implement a scaled back KMA system on a statewide basis, particularly for rural areas. Consider a clinical home approach with strong family supports and a regional pool of flex funds that are accessed by approved clinical home providers.
  - DPHHS should find methods to cover KMA case service planning activities as administrative expenses under Medicaid. This can be accomplished through the 1115 or 1915(b) waivers.
  - Finance continued training in systems of care and measuring fidelity to systems of care principles.
  - Provide state flex funding through the System of Care account authorized by HB 98 to replace federal grant funds when the grant terminates. Allocate a meaningful set of funds for each KMA's use. A statewide total of at least $250,000 may be sufficient to create meaningful regional pools of flex funds.
- Expand the DPHHS Extraordinary Case Review initiative and consider whether a more extensive chronic disease management approach should be implemented that focuses on mental illness. Review evidence on available models to identify those most likely to be both effective and efficient.
  - Provide pharmacy consultation and outreach for certain diagnostic groups.
  - Implement statewide telephonic support for individuals not receiving case management but needing education, support, referral and follow up.
  - Ensure that existing case managers coordinate closely with the primary care providers of their clients

Opportunities for Improving Accountability

- Develop a strategy for a pilot in Medicaid pay for performance. Incorporate this into the CCO scope or begin a planning process to implement it. This process will need to include key purchaser, consumer and ultimately provider stakeholders, and content experts in performance measurement and improvement.
- Designate a small pool of state general funds to be used for a pilot of performance contracting. Establish incentives for performance and/or tie them to attaining desirable client outcomes. Implement, measure (monthly or quarterly) and revise as needed over the next two or more years.
- Implement other quality improvement projects to create action on important performance improvement areas. These should be voluntary and intended to promote professional development as well as performance improvement. They should follow the

CMHB has been focusing considerable attention on bringing children back to Montana from out-of-state and strengthening community services for high need children in order to prevent residential placements. In addition to its initiation of the PRTF waiver demonstration, these efforts include the implementation of Children's System of Care and the use of a flexible System of Care account for services.

4. Children's System of Care

a) Background

Montana has been moving toward systems of care planning for children with complex needs since 2001, creating a multi-agency planning committee in 2001, a System of Care planning committee in 2003, and receiving a SAMHSA system of care grant in 2004, which is now beginning its fifth year. The grant helped the state to carry out the Legislature's directive to develop a system of care.

Systems of care is a way of planning and delivering services that enhances each family's role in identifying the services their child needs and developing and continuously adapting a service plan. System of care is targeted toward children with the most serious mental health problems, and those whose complex needs require services from more than one state agency. In addition to identifying and planning for a comprehensive set of state services, system of care focuses on identifying and further developing natural community resources that can be an ongoing source of support for the youth and family, and enhance their participation in community activities. In general, system of care projects include some limited form of flexible funding which is not required to meet standard reimbursement requirements, like those for Medicaid and Title IVE. This allows it to be used for non-traditional services that can complete service plans or allow a family to make best use of services. For example, funding a car repair may be the least expensive way to support a family's access to services. Paying for a swim program may allow a child access to a form of exercise and community participation that would not otherwise be available. Systems of care have been extensively researched and have often generated cost savings, reductions in out of home placements, and improved outcomes for youth and families.

b) SAMHSA Grant

Montana's system of care grant has involved five sites where local staff have been hired to develop local advisory committees, known as Kids Management Agencies (KMAs), and develop system of care planning processes. To date, 120 youth have been enrolled and approximately 70 meet the requirements for the federal evaluation. Although, flexible funds are quite limited, there has been considerable training of system of care staff, parents, and providers in the principles and practices of system of care, providing a necessary foundation for further implementation. However, Montana's current system of care delivery model is not well financed, and it will be challenging to find ways to sustain it in its current form.

In 2007, the Legislature established a System of Care account that allows state agencies to deposit the state share of any excess Medicaid match or other general fund dollars into the account. These funds can be used to purchase services on a flexible basis on behalf of high risk seriously emotionally disturbed children who have multi-agency service needs. Spending authority for the current biennium is set at a maximum of $500,000. In FY 2008, $46,000 was channeled through the account on behalf of 11 children. Nine of them would have required PRTF level of care without the ability to make these flexible expenditures. Another child was at risk of a disrupted adoption, and one would have been sent to an out of state group home.

Recommendations

We encourage DPHHS to continue its current efforts in screening of young children and in the expansion of disease management initiatives to include mental health conditions. As an example, DM efforts could identify and follow up on individuals receiving psychotropic medications but not receiving treatment to better understand the care they are receiving and to provide support to their primary care clinicians and prescribers.

3. Issue: Local Planning

Local Advisory Councils, Service Area Authorities and the Mental Health Oversight and Advisory Council have made progress in involving a broad group of consumers, family members and other stakeholders in planning, but further definition and development are needed. KMAs add another layer of organization in the community, planning for services at the individual case level. Often these are the same people who are serving on LACs and SAAs, and the boundary confusion is likely to be significant. In addition, boundaries are geographically inconsistent between adult and youth regions.

The Montana Legislature created Local Advisory Councils (or Committees) (LACs), Service Area Authorities (SAAs), and the Mental Health Oversight Advisory Council (MHOAC) to work with AMDD and CMHB. The majority of the members of MHOAC and the majority of the board of directors of the SAAs must be consumers or family members. People in each county are encouraged to participate in or form these councils to determine needs and suggest solutions to their SAA. In turn the SAA is to provide input to MHOAC. The process is cumbersome and the communication difficult. As a result there are many questions about roles and responsibilities.

Relatively few survey respondents identified LACs or SAAs as one of the strong features of Montana's mental health system. Approximately 3% to 6% ranked Local Advisory Councils an important strength, and 2% to 4% rated Service Area Authorities an important strength. Our interviews found that LACs and SAAs are still figuring out what they should do and how they should work together and with other entities.

The local planning functions are truly central to building responsive local systems of care for children and adults. Communities must take ownership of developing solutions to help and support their citizens. To achieve this, the LAC and SAA structures need more support and more emphasis on communities. It would help if child and adult regions were aligned; the different regional boundaries dilute the resources available to work with specific towns. Local officials need information to help them plan. This report and the detailed appendices should help them better understand the service utilization of their counties; more information should be developed annually to support them. Furthermore, regional staff from AMDD and CMHB need to learn effective organizing skills to empower these councils and facilitate their planning and problem solving.

According to stakeholders, the areas to be further defined include:

- The role of the state agency representatives who attend meetings.
- Support when co-leaders of LACs or SAAs have disagreements about agendas.
- Methods for consumer participants to engage effectively.
- The ability of the LAC and SAA to speak out publicly. Can they take public positions and advocate for them outside of the LAC/SAA process?

LACs don't explicitly include members of local courts and law enforcement. Their input would benefit planning for the mental health needs of individuals involved with the criminal justice system.

To reach their full promise, Local Advisory Councils need to be able to combine their experiential perspective with relevant data on service needs and service utilization in their area. Regular reporting can help them plan and evaluate the effectiveness of additions to the service network.

Recommendations

- Develop broader consensus on the vision, mission and goals of LAC and SAA community oversight. Clarify relationships and responsibilities between planning groups, councils and authorities – Do they operate on parallel but independent tracks? Do they review the same priorities? What is their relationship to DPHHS/AMDD? To the MHOAC?
- Make the geographic boundaries for planning areas consistent for adults and youth system so that resources can be consolidated to work more closely with communities.
- Modify LAC membership to include law enforcement representatives from local authorities and state offices.
- Improve flow of information to LACs and SAAs needed for their planning and monitoring functions. Develop standard reports that provide prevalence, program access, utilization and outcomes data for LACs and SAA areas and region in formats that allow comparison to regional and state averages. Consider building on the reporting framework laid out in this report for utilization and costs data by funding stream, service and county.